NSW GOVERNMENT Health

Facility:

ORAL HEALTH SPECIALIST REFERRAL

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Indicate referral centre (✓)	Sydney Dental Hospital ☐	Westmead Centre for Oral Health ☐	John Hunter Hospital ☐	Other _____
Postal Address	2 Chalmers St Surry Hills NSW 2010	PO BOX 533 Wentworthville NSW 2145	Locked Bag 1 Hunter Region Mail Centre NSW 2310	

Type of Specialist Service Required:

Patient Information:

Home number: | Mobile: | Work number:

Language spoken at home: | Country of Birth:

Interpreter required ☐ Yes ☐ No | Aboriginal Liaison Officer required ☐ Yes ☐ No

Medicare Card No. __ __ __ __ __ __ __ __ __ __ __ __ *(please provide all 11 numbers)*

Concession card: HCC or PCC *(please circle)* | **Card No:** | **Start date:** | **Expiry date:**

Referring Practitioner ☐ Medical ☐ Dental ☐ Other

Type: ☐ General ☐ Specialist Specialty _____

Name:

Address:

Telephone: Fax: Email:

Signature: Date:

Patient's Medical and Dental Information

1. Significant medical history: *(include any relevant access issues / special requirements / guardianship)*

2. Reason for referral and treatment history: (please ✓ the relevant box below to identify your request)

I request: ☐ an opinion ☐ opinion and management by a specialist ☐ general care (student only)

3. Provisional treatment plan:

4. Enclosures *(please identify type e.g. radiograph, reports)*

- _____
- _____
- _____

Office Use Only: Clinic/Dept: _____ Waiting List _____

Date entered: _____ Signed: _____

SMR010741

Holes punched as per AS2828.1:2012

BINDING MARGIN - NO WRITING

ORAL HEALTH SPECIALIST REFERRAL SMR010.741

NH606531 040714

NO WRITING